

Facility Name & ID Number

LITCHFIELD TERRACE

#

0032946

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	65Intermediate (ICF)	65	23,725	3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	65TOTALS	65	23,725	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8	SNF				8
9	SNF/PED				9
10	ICF	18,743	986	19,729	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	18,743	986	19,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

83.16%

D. How many bed-hold days during this year were paid by Public Aid?

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

11/06/87

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

11/06/87

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

X

If YES, enter number of beds certified

and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2003

Fiscal Year:

12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **LITCHFIELD TERRACE** # **0032946** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	87,129	6,960	4,515	98,604		98,604		98,604			1
2	Food Purchase		68,165		68,165		68,165	(359)	67,806			2
3	Housekeeping	41,065	5,193		46,258		46,258		46,258			3
4	Laundry	24,286	3,913		28,199		28,199		28,199			4
5	Heat and Other Utilities			50,104	50,104		50,104	1,327	51,431			5
6	Maintenance	18,779	12,647	15,216	46,642		46,642	(4,304)	42,338			6
7	Other (specify):*			3,396	3,396		3,396	70	3,466			7
8	TOTAL General Services	171,259	96,878	73,231	341,368		341,368	(3,266)	338,102			8
	B. Health Care and Programs											
9	Medical Director			5,700	5,700		5,700		5,700			9
10	Nursing and Medical Records	416,219	12,461	7,365	436,045		436,045	7,505	443,550			10
10a	Therapy											10a
11	Activities	31,365	867	4,784	37,016		37,016	(3,110)	33,906			11
12	Social Services	89,618	660		90,278		90,278		90,278			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	537,202	13,988	17,849	569,039		569,039	4,395	573,434			16
	C. General Administration											
17	Administrative	49,808		3,000	52,808		52,808	5,632	58,440			17
18	Directors Fees											18
19	Professional Services			112,014	112,014		112,014	(86,567)	25,447			19
20	Dues, Fees, Subscriptions & Promotions			5,580	5,580		5,580	(928)	4,652			20
21	Clerical & General Office Expenses	40,748	5,781	17,994	64,523		64,523	37,578	102,101			21
22	Employee Benefits & Payroll Taxes			104,457	104,457		104,457		104,457			22
23	Inservice Training & Education			868	868		868	244	1,112			23
24	Travel and Seminar			146	146		146	6,434	6,580			24
25	Other Admin. Staff Transportation			3,951	3,951		3,951	3,652	7,603			25
26	Insurance-Prop.Liab.Malpractice			57,560	57,560		57,560	442	58,002			26
27	Other (specify):*			8,115	8,115		8,115	1,658	9,773			27
28	TOTAL General Administration	90,556	5,781	313,685	410,022		410,022	(31,855)	378,167			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	799,017	116,647	404,765	1,320,429		1,320,429	(30,726)	1,289,703			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	4,515
	REPAIRS & MAINTENANCE		0
			0
			4,515
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		6,759
	ELECTRICITY		30,936
	WATER		12,132
	CABLE TV - LOBBY		277
			0
			50,104
6	MAINTENANCE		
	GROUNDS MAINTENANCE		1,155
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE CONSULTANT		11,447
	EQUIPMENT MAINTENANCE & REPAIR		0
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		2,614
			0
			0
			0
			15,216
7	OTHER		
	SCAVENGER		3,396
	SECURITY SERVICE		0
			3,396
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,700
			5,700

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	6,165
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	600
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	600
			0
			0
			7,365
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,784
			0
			4,784
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 3,000	3,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 7,918	
	ADMINISTRATIVE CONSULTANTS	XIX C 18,385	
	PROFESSIONAL FEES	XIX C 16,088	
	BOOKKEEPING/ADMINIST. SERVICE	69,623	112,014
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 233	
	EMPLOYEE WANT ADS	XIX F 102	
	CONTRIBUTIONS	VI 20 XIX F 180	
	DUES & SUBSCRIPTIONS	XIX F 2,659	
	LICENSES & PERMITS	XIX F 1,550	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 856	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	5,580
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	561	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 2,520	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	12,713	
	MESSENGER SERVICE	2,200	
		0	17,994

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 61,305	
	UNEMPLOYMENT COMPENSATION	XIX D 9,281	
	WORKERS COMPENSATION INSURANCE	XIX D 15,600	
	HOSPITALIZATION INSURANCE	XIX D 14,880	
	EMPLOYEE BENEFITS - OTHER	XIX D 3,391	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	104,457
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	868	868
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 146	
		0	
		0	146
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	3,951	3,951
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	57,560	57,560
27	OTHER		
	BAD DEBTS	VI 24 8,115	
		0	8,115

GRAND TOTAL COLUMN 3 OTHER

404,765

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			5,799	5,799		5,799	18,350	24,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,668	13,668		13,668	102,562	116,230			32
33	Real Estate Taxes			16,108	16,108		16,108		16,108			33
34	Rent-Facility & Grounds			118,538	118,538		118,538	(113,630)	4,908			34
35	Rent-Equipment & Vehicles			11,791	11,791		11,791	4,982	16,773			35
36	Other (specify):*											36
37	TOTAL Ownership			165,904	165,904		165,904	12,264	178,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,587	35,587		35,587		35,587			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	799,017	116,647	606,256	1,521,920		1,521,920	(18,462)	1,503,458			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(678)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(359)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,520)	21		18
19	Entertainment		20		19
20	Contributions	(1,036)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,115)	27		24
25	Fund Raising, Advertising and Promotional	(233)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,941)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(5,521)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,521)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (18,462)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING
		RIVER VIEW MANOR	LOVES PARK	ENTERPRISES, LTD.		BOOKKEEPING
		PARKVIEW TERRACE	EAST MOLINE			
SEE ATTACHED LIST		GOLDEN MOMENTS	JACKSONVILLE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTANT	\$ 11,447			\$	\$ (11,447)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	3,165				(3,165)	2
3	V	11	ACTIVITIES CONSULTANT	3,110				(3,110)	3
4	V	19	ADMIN. /BKBP. FEES	69,623				(69,623)	4
5	V	19	ADMIN. /CONSULT. FEES	18,385				(18,385)	5
6	V								6
7	V	5	ELECTRICITY/GAS				1,327	1,327	7
8	V	6	MAINTENANCE				7,143	7,143	8
9	V	7	SCAVENGER				70	70	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				10,670	10,670	10
11	V	17	ADMINISTRATIVE SALARIES				5,632	5,632	11
12	V	19	PROFESSIONAL FEES				1,441	1,441	12
13	V	20	ADVERTISING				341	341	13
14	Total			\$ 105,730			\$ 26,624	\$ * (79,106)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES, LTD.		\$ 40,098	\$ 40,098	15
16	V	23	SEMINARS				244	244	16
17	V	24	TRAVEL				6,434	6,434	17
18	V	25	TRANSPORTATION				3,652	3,652	18
19	V	27	EMPLOYEE BENEFITS				9,773	9,773	19
20	V	30	DEPRECIATION (SL)				319	319	20
21	V	32	INTEREST				84	84	21
22	V	34	OFFICE RENT				4,908	4,908	22
23	V	35	EQUIPMENT RENT				4,982	4,982	23
24	V	26	INSURANCE				442	442	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 70,936	\$ * 70,936	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 118,538	IDEA ASSOCIATES		\$	(118,538)	15
16	V	30	DEPRECIATION				18,709	18,709	16
17	V	32	INTEREST				102,478	102,478	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 118,538			\$ 121,187	\$ * 2,649	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7			SEE ATTACHED LIST								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 2/31/2003

(847) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	141,473	7	\$ 9,514	\$	19,729	\$ 1,327	1
2	6	MAINTENANCE	PATIENT DAYS	141,473	7	51,216	50,100	19,729	7,143	2
3	7	SCAVENGER	PATIENT DAYS	141,473	7	500		19,729	70	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	141,473	7	76,511		19,729	10,670	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	141,473	7	40,388	40,388	19,729	5,632	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	141,473	7	10,333		19,729	1,441	6
7	20	ADVERTISING	PATIENT DAYS	141,473	7	2,442		19,729	341	7
8	21	TOTAL OFFICE	PATIENT DAYS	141,473	7	287,536	218,675	19,729	40,098	8
9	23	SEMINARS	PATIENT DAYS	141,473	7	1,750		19,729	244	9
10	24	TRAVEL	PATIENT DAYS	141,473	7	46,140		19,729	6,434	10
11	25	TRANSPORTATION	PATIENT DAYS	141,473	7	26,191		19,729	3,652	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	141,473	7	70,083		19,729	9,773	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	141,473	7	2,285		19,729	319	13
14	32	INTEREST	PATIENT DAYS	141,473	7	601		19,729	84	14
15	34	OFFICE RENT	PATIENT DAYS	141,473	7	35,195		19,729	4,908	15
16	35	EQUIPMENT RENT	PATIENT DAYS	141,473	7	35,725		19,729	4,982	16
17	26	INSURANCE	PATIENT DAYS	141,473	7	3,172		19,729	442	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 699,582	\$ 309,163		\$ 97,560	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	RELATED PARTY						\$					\$	1
2	IDEA ASSOCIATES												2
3	BANK FINANCIAL		X	MORTGAGE	DEMAND	10/98		874,500	838,214			102,478	3
4													4
5	MGMT CO ALLOCATION											84	5
	Working Capital												
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	11/01/97		150,000			5.2500	10,807	6
7	A.I. CREDIT CORPORATION		X	INSURANCE FINANSING								2,861	7
8													8
9	TOTAL Facility Related						\$	1,024,500	\$	838,214			9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	1,024,500	\$	838,214			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

16	AMOUNT TO USE FOR RATE CALCULATION \$
----	---------------------------------------

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

LITCHFIELD TERRACE

COUNTY

MONTGOMERY

FACILITY IDPH LICENSE NUMBER

0032946

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	16-001-925-00	NURSING HOME	\$ 14,808.04	\$ 14,808.04
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 14,808.04	\$ 14,808.04

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		1987		\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 243,162	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1989		12,200	127	20	610	483	4,013	9
10	VARIOUS		1990		11,968	349	20	598	249	4,891	10
11	VARIOUS		1991		4,250	135	20		(135)	4,250	11
12	VARIOUS		1992		14,226	197	20	711	514	5,564	12
13	VARIOUS		1993		5,350	170	20		(170)	5,350	13
14	VARIOUS		1994		2,312	25	20		(25)	2,312	14
15	GARBAGE DISPOSAL		1996		695		20	35	35	257	15
16	TILE		1997		2,778	71	20	139	68	849	16
17	WATER HEATER		1998		2,107	54	20	105	51	577	17
18	AIR CONDITIONERS		2000		1,477	54	27.5	54		190	18
19	REPAIR ROOF		2000		1,700	62	27.5	62		218	19
20	SPRINKLERS		2000		2,961	108	27.5	108		380	20
21	ROOF REPAIR		2002		6,450	147	27.5	147		294	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$657,816	\$20,208		\$21,278	\$1,070	\$272,307	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 52,799	\$ 4,300	\$ 2,552	\$ (1,748)	8-10	\$ 36,052	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		319	319				74
75	TOTALS	\$ 52,799	\$ 4,619	\$ 2,871	\$ (1,748)		\$ 36,052	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	710,615
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	24,827
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	24,149
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(678)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	308,359

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 3,991
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2000 DODGE RAM	\$ 650.00	\$ 7,800	17
18					18
19					19
20					20
21	TOTAL		\$ 650.00	\$ 7,800	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,028	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	240,937		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,121		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,465,304		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,750,390	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	49,452		15
16	Equipment, at Historical Cost	69,518		16
17	Accumulated Depreciation (book methods)	(74,481)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,489	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,794,879	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 299,081	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,201		28
29	Short-Term Notes Payable	304,406		29
30	Accrued Salaries Payable	31,056		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,594		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,956		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 764,294	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 764,294	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,030,585	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,794,879	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,110,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,110,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(79,938)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (79,938)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,030,585	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,441,868	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,441,868	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	114	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 114	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,441,982	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	341,368	31
32	Health Care	569,039	32
33	General Administration	410,022	33
	B. Capital Expense		
34	Ownership	165,904	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,521,920	40
41	Income before Income Taxes (line 30 minus line 40)**	(79,938)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (79,938)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,937	2,116	\$ 47,370	\$ 22.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	629	748	15,565	20.81	3
4	Licensed Practical Nurses	8,011	8,795	136,204	15.49	4
5	Nurse Aides & Orderlies	21,526	23,507	189,592	8.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,028	3,382	31,365	9.27	10
11	Social Service Workers	6,777	7,671	89,618	11.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,866	9,823	87,129	8.87	15
16	Dishwashers					16
17	Maintenance Workers	1,634	1,929	18,779	9.74	17
18	Housekeepers	4,486	4,986	41,065	8.24	18
19	Laundry	2,532	3,002	24,286	8.09	19
20	Administrator	2,016	2,142	49,808	23.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,959	6,174	40,748	6.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	1,515	1,764	27,488	15.58	33
34	TOTAL (lines 1 - 33)	68,916	76,039	\$ 799,017 *	\$ 10.51	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,515	1-3	35
36	Medical Director	O	5,700	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	600	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,784	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANT	S	6,165	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,364		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
BARBARA LOWRY	ADMIN		\$ 49,808	Workers' Compensation Insurance	\$	15,600	IDPH License Fee	\$ 400
			0	Unemployment Compensation Insurance		9,281	Advertising: Employee Recruitment	102
				FICA Taxes		61,305	Health Care Worker Background Check	0
				Employee Health Insurance		14,880	(Indicate # of checks performed)	
				Employee Meals		#REF!	MARKETING/ADV/PROMO	233
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	1,036
				EMPLOYEE BENEFITS - OTHER		3,391	LICENSES & PERMITS	1,150
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	2,659
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	341
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 49,808	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(1,036)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other							Non-allowable advertising	(233)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(0)
MELVIN SIEGEL			\$ 3,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 3,000	TOTAL (agree to Schedule V, line 22, col.8)	\$	#REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,652
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								146
							MGMT CO ALLOCATION	6,434
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			112,014				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 112,014	TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL	\$ 6,580

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$2367
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,587
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees